

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-013945
STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. 374 Primary Registration District No. 6276 Registrar's No. 10

FILED APR 4 1962

1. PLACE OF DEATH a. COUNTY <u>Worth</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Worth</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Isadora</u>		c. CITY OR TOWN <u>Isadora</u>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION		d. STREET ADDRESS (If outside, give location)	
Length of stay in lb <u>Life</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) <u>Orion John Merckling</u>			4. DATE OF DEATH Month <u>March</u> Day <u>20</u> , Year <u>1962</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>10-3-1895</u>	9. AGE (last birthday) <u>66</u>	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>		11. BIRTHPLACE (City and state or country) <u>Near Grant City, Mo.</u>	
12. CITIZEN OF WHAT COUNTRY <u>U. S.</u>					

13a. FATHER'S NAME <u>John Wesley Merckling</u>		13b. MOTHER'S MAIDEN NAME <u>Emma Myrtle Lang</u>		14. NAME OF HUSBAND OR WIFE <u>Mildred May Merckling</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>[REDACTED]</u>		17. INFORMANT Address <u>Mrs. Mildred Merckling-Grant City, Mo.</u>	

18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Paralysis Agitans</u>		INTERVAL BETWEEN ONSET AND DEATH <u>4years</u>
DUE TO (b) <u>Generalized Arteriosclerosis</u>		<u>4yrs</u>
DUE TO (c) <u> </u>		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
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19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour <u> </u> Month, Day, Year <u> </u> a.m. <u> </u> p.m. <u> </u>			

20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION <u>1947</u> <u>20 Mar 62</u>	COUNTY <u> </u> STATE <u> </u>
21. I attended the deceased from <u>March 20, 1962</u> to <u>12:30P</u> and last saw her alive on <u>18 Mar 62</u> Death occurred at <u>March 20, 1962</u> on the date stated above, and to the best of my knowledge, from the causes stated.			

22a. SIGNATURE <u>Frank B. Madison MD</u>	(Degree or title)	22b. ADDRESS <u>Grant City, Missouri</u>	22c. DATE SIGNED <u>3-24-62</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>3-21-1962</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Isadora Cemetery</u>	23d. LOCATION (City, town, or county) <u>Isadora, Missouri</u>	(State)
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24. FUNERAL DIRECTOR <u>Bill A. Dunfee</u>	ADDRESS <u>Grant City, Mo</u>	25. DATE RECD. BY LOCAL REG. <u>March 30, 1962</u>	26. REGISTRAR'S SIGNATURE <u>Leta E. Dawson</u>
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(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK
OR
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

VS 300
Rev. 4/59

1/130

2/130

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STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Bill A. Dunfee
Licensed Embalmer No. 4908

P. O. Address Summit City, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.